General

Guideline Title

Uniform labeling of blocks and slides in surgical pathology: guideline from the College of American Pathologists Pathology and Laboratory Quality Center and the National Society for Histotechnology.

Bibliographic Source(s)

Brown RW, Della Speranza V, Alvarez JO, Eisen RN, Frishberg DP, Rosai J, Santiago J, Tunnicliffe J, Colasacco C, Lacchetti C, Thomas NE. Uniform labeling of blocks and slides in surgical pathology: guideline from the College of American Pathologists Pathology and Laboratory Quality Center and the National Society for Histotechnology. Arch Pathol Lab Med. 2015 Dec;139(12):1515-24. [22 references] PubMed

Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

Recommendations

Major Recommendations

The grades for strength of recommendations (Strong recommendation, Recommendation, Expert consensus opinion, No recommendation) are defined at the end of the "Major Recommendations" field.

Guideline Statements

1. Laboratories should ensure that all blocks and slides are unambiguously labeled using 2 patient identifiers. (Recommendation)
2. Laboratories should ensure that the accession designation used on the surgical pathology report, and all blocks and slides from that accession, includes the case type (surgical pathology versus cytology or autopsy), the year, and a unique accession number. (Expert consensus opinion)
   Example: S14-9999 (surgical case–year-accession number)

   Note: Laboratories may position the information in a different format (e.g., 14-9999S, 14S-9999) and may include additional letters that reflect the hospital or clinic site of origin.

3. If the patient's name is used as one of the patient identifiers, laboratories should ensure that the name format will link the blocks and slides to the correct patient. (Expert consensus opinion)
   Note: Possible formats include, but are not limited to, full last and first name, full last name with first initial, or an appropriate number of letters of the last and first names.

4. When an accession number has not yet been assigned (e.g., frozen sections or intraprocedural consultations), laboratories should label the blocks and slides with at least 2 patient identifiers, 1 of which is the patient name. (Recommendation)
   Note: Possible additional identifiers include, but are not limited to, date of birth, medical record number, or unique health identification number.

5. Laboratories should label each specimen container with a unique alphanumeric designation that incorporates the accession designation. Each block and slide from that specimen container should be labeled with the same unique alphanumeric designation. (Expert consensus opinion)
6. Laboratories should label each block obtained from a single specimen sequentially with a unique alphanumeric designation that can be unambiguously linked to a gross description within the pathology report. The order should be accession designation, specimen identifier, and block identifier. Laboratories may select the format of the specimen/block identifier. (Expert consensus opinion)
   Example: For specimen A, blocks are labeled 1, 2, 3 . . . (S14-9999 A1, A2, A3 . . .) For specimen 1, blocks are labeled A, B, C . . . (S14-9999-1A, 1B, 1C . . .)

7. When multiple slides are cut from a single block, laboratories should label each slide sequentially in order of cutting. This slide identifier should come after the specimen identifier and block identifier. (Expert consensus opinion)
   Example: S14-9999-A1-1, S14-9999-A1-2, S14-9999-A1-3

   Note: The laboratory may determine the exact labeling format for multiple slides.

8. The laboratory should label the slides with the histochemical, immunohistochemical, and/or special procedure (e.g., FS for frozen section, TP for touch preparation, AFB for acid-fast bacteria) after the accession, specimen, block, and slide identifiers. The histochemical technique or specific antibody used should also be included when it may affect the interpretation. (Expert consensus opinion)
   Examples:

   S14-9999-A1-1
   FS
   S14-9999-A1-1
   Cytokeratin (AE1/AE3)
   S14-9999-A1-1
   AFB (Ziehl-Neelsen, Wade-Fite, etc)

   Note: The panel concludes that surgical pathology slides labeled with terms such as "recut," "level," or "deeper" and slides without an explicit stain name are inherently implied to be a hematoxylin-eosin stain; no additional labeling is required. The panel also concludes that the labeling of control slides or control tissue on test slides is beyond the scope of this guideline; however, the panel concludes that laboratories should establish a clear and standardized method for distinguishing control tissues from patient tissues that can be understood internally and externally.

9. No recommendation is made regarding standardization of abbreviations and conventions. (No recommendation)
10. On paraffin blocks, the accession designation should be the most prominent printed element (i.e., larger font or bolded), followed by the patient name or other second identifier. As long as the ability to read the accession designation and second identifier is not compromised, additional elements may be included as determined by the laboratory. (Expert consensus opinion)
11. On microscopic slides, the accession designation should be the most prominent printed element (i.e., larger font or bolded) followed by the patient name or other second identifier and stain/procedure name. As long as the ability to read these essential elements is not compromised, additional elements may be included as determined by the laboratory. (Expert consensus opinion)
12. Laboratories should label blocks and slides received in consultation with their own institution's accession designation. Laboratories should not obscure the original label when relabeling. (Expert consensus opinion)

Definitions

Grades for Strength of Evidence

Grade	Description
Convincing	Two or more level 1[a] or level 2 studies (study design and execution) that had an appropriate number and distribution of challenges[b] and reported consistent[c] and generalizable[d] results. One level 1 or level 2 study that had an appropriate number and distribution of challenges and reported generalizable results.
Adequate	Two or more level 1 or level 2 studies that lacked the appropriate number and distribution of challenges OR were consistent but

Grade	Description
	not generalizable.
Inadequate	Combinations of level 1 or level 2 studies that show unexplained inconsistencies OR one or more level 3 or level 4 studies OR expert opinion.

From Teutsch SM, Bradley LA, Palomaki GE, et al. The Evaluation of Genomic Applications in Practice and Prevention (EGAPP) Initiative: methods of the EGAPP Working Group. Genet Med. 2009;11(1):3–14. Reprinted with permission from Macmillan Publishers Ltd.

[a]Supplemental Table 2 in the supplemental digital content (see the "Availability of Companion Documents" field) provides the hierarchy of data sources for analytic validation that define Level 1 through Level 4.

[b]Based on number of possible response categories and required confidence in results.

[c]Consistency can be assessed formally by testing for homogeneity, or, when data are limited, less formally using central estimates and range of values.

[d]Generalizability is the extension of findings and conclusions from one study to other settings.

Grades for Strength of Recommendations

Designation	Recommendation	Rationale
Strong Recommendation	Recommend For or Against a particular block or slide labeling practice (can include must or should).	Supported by high (convincing) or intermediate (adequate) quality of evidence and clear benefit that outweighs any harms.
Recommendation	Recommend For or Against a particular block or slide labeling practice (can include should or may).	Some limitations in quality of evidence (intermediate [adequate] or low [inadequate]), balance of benefits and harms, values, or costs, but panel concludes that there is sufficient evidence to inform a recommendation.
Expert Consensus Opinion	Recommend For or Against a particular block or slide labeling practice (can include should or may).	Serious limitations in quality of evidence (low [inadequate] or insufficient), balance of benefits and harms, values, or costs, but panel consensus is that a statement is necessary.
No Recommendation	No recommendation for or against a particular block or slide labeling practice.	Insufficient evidence, confidence, or agreement to provide a recommendation.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Any disease or condition requiring pathological evaluation of patient biopsy and surgical tissue specimens in paraffin blocks or microscopic glass slides

Guideline Category

Evaluation

Clinical Specialty

Pathology

Intended Users

Clinical Laboratory Personnel

Physician Assistants

Physicians

Guideline Objective(s)

- To develop recommendations that will address the need for adequate patient identification and provide a consistent method of identifying slides originating from a particular block
- To address the overarching question "What are the essential elements for the proper labeling of paraffin blocks and microscopic slides in the routine practice of surgical pathology?" The key questions are as follows:
    1. What are the unique patient identifiers required for the unambiguous labeling of blocks and slides?
    2. What elements are required for the unambiguous labeling of blocks and slides with site of origin (specimen and, within the specimen, correlation with gross description)?
    3. When additional studies (deeper sections, histochemical stains immunohistochemistry) are requested, what information should be included on the resulting slides?
        a. How should you identify the different types of slides that have been cut? (i.e., step sections have different meanings across laboratories)
        b. How would one determine the appending of numbers of subsequent slides?
        c. What standards should apply for the unique labeling of slides that have been stained with histochemical or immunohistochemical techniques?
    4. What is the value of standardizing the abbreviations and conventions used in key question 3?
    5. In what order should the essential elements appear on the slide, and, if space precludes inclusion of all, what is the priority?
    6. How should you label blocks and slides received in consultation?

Target Population

Patients with any disease or condition requiring pathological evaluation of biopsy and surgical tissue specimens in paraffin blocks or microscopic glass slides

Interventions and Practices Considered

Standardized block and slide labeling practices:

1. Unambiguous labeling using patient identifiers
2. Accession designation including case type, year, and unique accession number
3. Format and order of identifying elements
4. Labeling to indicate histochemical, immunohistochemical or special procedure

Major Outcomes Considered

- Misidentification of paraffin blocks and microscopic glass slides
- Incorrect diagnosis, therapy, or procedure to the patient due to mislabeling
- Histotechnologist error (cutting the wrong paraffin block or mixing cases)
- Misidentification of glass slides and paraffin blocks sent for consultative interpretation

Methodology

Methods Used to Collect/Select the Evidence

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Literature Search and Selection

The literature search strategy involved searching the following electronic databases from January 2002 through January 2013: Ovid MEDLINE, Ovid MEDLINE In-Process & Other Non-indexed Citations, PubMed, and Web of Science. Relevant meeting abstracts and pathology journal tables of contents were hand searched (2011-2013). Applicable pathology monographs were identified (2002-2012). The bibliographies of identified articles were reviewed for relevant reports, and citation reports (Scopus, Web of Science) for included articles were also reviewed. See the supplemental digital content (see the "Availability of Companion Documents" field) for the complete literature search strategy.

Inclusion Criteria

Published studies were selected for full-text review if they met each of the following criteria:

1. Surgical pathology studies
2. Original research addressing the labeling of blocks and/or microscopic slides
3. English language articles of any study design
4. Animal and human studies

Exclusion Criteria

Studies that did not include original data regarding the labeling of blocks or microscopic slides, autopsy or cytopathology studies, and studies that focused exclusively on specimen container labeling were excluded. Editorials, letters, commentaries, invited opinions, articles not written in English, and articles that did not address any key question were also excluded.

Please see the supplemental digital content for further information regarding the literature search.

Number of Source Documents

Of the 456 studies identified by the systematic literature review, 10 peer-reviewed articles met inclusion criteria and underwent data extraction. However, these studies ultimately failed to meet the minimum quality standards, presented incomplete data, or only included information based on expert opinion.

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Grades for Strength of Evidence

Grade	Description
Convincing	Two or more level 1[a] or level 2 studies (study design and execution) that had an appropriate number and distribution of challenges[b] and reported consistent[c] and generalizable[d] results. One level 1 or level 2 study that had an appropriate number and distribution of challenges and reported generalizable results.
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[c]Consistency can be assessed formally by testing for homogeneity, or, when data are limited, less formally using central estimates and range of values.

[d]Generalizability is the extension of findings and conclusions from one study to other settings.

Methods Used to Analyze the Evidence

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Data Extraction and Management

The data elements from an included article/document were extracted by one reviewer into standard data formats and tables developed using systematic review database software (DistillerSR, Evidence Partners Inc., Ottawa, Canada); a second reviewer confirmed accuracy and completeness. Any discrepancies in data extraction were resolved by discussion with the methodologist. A bibliographic database was established in EndNote (Thomson Reuters, Carlsbad, CA) to track all literature identified and reviewed during the study.

Quality Assessment

Articles meeting the inclusion criteria were assessed for strength of evidence, methodologic rigor, and confirmation of validity by a contracted methodologist. The quality assessment of the studies was informed by several instruments, based on study design. The other components of evidence such as generalizability and applicability to labeling of blocks and slides in surgical pathology were also considered when determining the strength of evidence.

For strength of the evidence, the panel considered the level of evidence, its quantity, and quality of included studies. The level of evidence was based on the study design as follows: level I was evidence from systematic reviews of appropriate level II studies; level II was evidence from good-quality randomized controlled trials; level III was evidence from low-quality comparative studies; level IV was evidence from studies without a comparator. In general, level I and II evidence is considered most appropriate to answer clinical questions, but in the absence of such high-quality evidence, the panel considered data from lower-quality studies. The quantity of evidence refers to the number of studies and number of cases included for each outcome in the recommendation. The quality of studies reflects how well the studies were designed to eliminate bias and threats to validity.

The methodologic quality of preimplementation and postimplementation studies was assessed using 4 elements of the Ramsay et al. quality criteria for interrupted time series designs. Scientific quality assessment of prospective case series was informed by the Centre for Reviews and Dissemination's guidance for reviews. The 3 elements considered included the representativeness of the sample, the sufficiency of the follow-up period, and the application of objective criteria to assess study outcomes. Finally, the qualitative study was assessed for methodologic quality using 5 components of the National Institute for Health and Care Excellence's (NICE's) 2009 methodology checklist for qualitative studies. The appropriateness of the study design and data collected, relevance and clarity of findings, and adequacy of conclusions were evaluated. Each study was assessed individually, and then studies were summarized by study type. Finally, a summary of the overall quality of the evidence was given considering the evidence in totality.

See the supplemental digital content (see the "Availability of Companion Documents" field) for further details on the quality assessment and results.

Methods Used to Formulate the Recommendations

Description of Methods Used to Formulate the Recommendations

Panel Composition

The College of American Pathologists (CAP) Pathology and Laboratory Quality Center convened an expert panel consisting of members with expertise in surgical pathology and histotechnology. Panel members included pathologists, histotechnologists, a methodologist consultant, and CAP staff. The CAP and National Society for Histotechnology (NSH) approved the appointment of the project cochairs and panel members. These panel members served as the expert panel for the systematic evidence review.

Assessing the Strength of Recommendations

The central question that the panel addressed in developing the guideline was "What are the essential elements for the proper labeling of paraffin blocks and microscopic slides in the routine practice of surgical pathology?"

Development of recommendations required that the panel review the identified evidence and make a series of key judgments:

1. What are the significant findings related to each key question or outcome? Determine any regulatory requirements and/or evidence that support a specific action.
   What is the overall strength of evidence supporting each key question or outcome? Strength of evidence is graded as Convincing, Adequate or Inadequate, based on four published criteria (see the "Rating Scheme for the Strength of the Evidence" field). Strength of evidence is a key element in determining the strength of a recommendation.
2. What is the strength of each recommendation? There are many methods for determining the strength of a recommendation based on the strength of evidence and the magnitude of net benefit or harm. However, such methods have rarely (if ever) been applied to the area of slide/block labeling. Therefore, the method for determining strength of recommendation has been modified for this application (see the "Rating Scheme for the Strength of the Recommendations" field), and is based on the strength of evidence and the likelihood that further studies will change the conclusions. Recommendations not supported by evidence (i.e., evidence was missing or insufficient to permit a conclusion to be reached) were made based on consensus expert opinion. Another potential consideration is the likelihood that additional studies will be conducted that fill gaps in knowledge.
3. What is the net balance of benefits and harms? The consideration of net balance of benefits and harms will focus on the core recommendation to unambiguously identify blocks and slides in surgical pathology.

Results

As the overall body of available evidence was deemed inadequate to inform the guidelines, the panel relied on expert consensus opinion to formulate 10 of the 12 recommendations. Two of the recommendations were informed by existing regulatory requirements and were further guided by the clinical experience of the panel, resulting in a strong consensus.

The expert panel met 12 times through teleconference webinars from April 2012 through March 2014. Additional work was completed via electronic mail. The panel met in person August 17, 2013, to review evidence to date and draft recommendations and March 22, 2014, to draft the manuscript.

"Agree" and "disagree" responses were captured for every proposed recommendation. The Web site also received 539 written comments. Ten of 13 recommendations achieved more than 80% agreement; the other 3 achieved 78% to 79% agreement. Each expert panel member was assigned 3 or 4 draft recommendations for which to review all comments received and provide an overall summary to the rest of the panel. One draft recommendation was maintained with the original language, 10 were modified with minor changes and/or additions for clarification, and 2 of the draft recommendations were combined, for a total of 12 final recommendations. Resolution of all changes was obtained by majority consensus of the panel using nominal group technique (rounds of teleconference webinars, e-mail discussion, and multiple edited recommendations) among the panel members. The final recommendations were approved by the expert panel with a formal vote. The panel considered laboratory efficiency and the feasibility of the recommendations throughout the entire process.

Rating Scheme for the Strength of the Recommendations

Grades for Strength of Recommendations

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No Recommendation	No recommendation for or against a particular block or slide labeling practice.	Insufficient evidence, confidence, or agreement to provide a recommendation.

Cost Analysis

A formal analysis of cost or cost effectiveness was not performed.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

An open comment period was held from November 4 through December 6, 2013. Thirteen draft recommendations were posted online on the National Society for Histotechnology (NSH) Web site. The final recommendations were approved by the expert panel with a formal vote.

An independent review panel, masked to the expert panel and vetted through the conflict of interest process, provided final review of the guideline and a recommendation for approval by the College of American Pathologists (CAP) and NSH.

Note: For a list of external peer reviewers see the supplemental digital content (see the "Availability of Companion Documents" field).

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

- The Panel believes that the use of two identifiers on tissue blocks and slides affords a greater opportunity to avoid error and a greater opportunity to discover an error if one occurs. The use of two identifiers provides an opportunity to correlate and check two data points against each other, providing a greater degree of assurance. For those facilities that use barcodes, the inclusion of human readable identifiers provides a safeguard against printer failures which can yield barcodes that will not scan, system downtime occurrences, and the occurrence of barcodes from one institution that may be unreadable at a second institution where a consultation is sought.

- The Panel further believes that implementation of a uniform labeling standard with regard to the specific elements needed to unambiguously link each tissue block and the slides derived from it with a specific patient and tissue source will decrease the likelihood that these preparations will be misinterpreted within an institution or in other facilities to which they may be referred.

Potential Harms

For laboratories that label cassettes and slides by hand, incorporation of additional information in fields that have limited space will be challenging and force individuals to write more carefully and deliberately. Rushed labeling may lead to illegible notations and increased identification errors. The use of two identifiers will therefore force individuals to slow down, which may negatively impact workflow in busy laboratories, affecting sample turnaround times.

Qualifying Statements

Qualifying Statements

The College of American Pathologists (CAP) developed the Pathology and Laboratory Quality Center as a forum to create and maintain evidence-based practice guidelines and consensus statements. Practice guidelines and consensus statements reflect the best available evidence and expert consensus supported in practice. They are intended to assist physicians and patients in clinical decision making and to identify questions and settings for further research. With the rapid flow of scientific information, new evidence may emerge between the time a practice guideline or consensus statement is developed and when it is published or read. Guidelines and statements are not continually updated and may not reflect the most recent evidence. Guidelines and statements address only the topics specifically identified therein and are not applicable to other interventions, diseases, or stages of diseases. Furthermore, guidelines and statements cannot account for individual variation among patients and cannot be considered inclusive of all proper methods of care or exclusive of other treatments. It is the responsibility of the treating physician or other health care provider, relying on independent experience and knowledge, to determine the best course of treatment for the patient. Accordingly, adherence to any practice guideline or consensus statement is voluntary, with the ultimate determination regarding its application to be made by the physician in light of each patient's individual circumstances and preferences. The CAP and National Society for Histotechnology (NSH) make no warranty, express or implied, regarding guidelines and statements and specifically exclude any warranties of merchantability and fitness for a particular use or purpose. The CAP and NSH assume no responsibility for any injury or damage to persons or property arising out of or related to any use of this statement or for any errors or omissions.

Implementation of the Guideline

Description of Implementation Strategy

The College of American Pathologists (CAP) plans to host a Uniform Labeling resource page which will include a link to manuscript and supplement; a summary of the recommendations, a teaching PowerPoint and a frequently asked question (FAQ) document. The guideline will be promoted and presented at various society meetings.

Implementation Tools

Quick Reference Guides/Physician Guides

Resources

Slide Presentation

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report

Categories

IOM Care Need

Staying Healthy

IOM Domain

Effectiveness

Safety

Identifying Information and Availability

Bibliographic Source(s)

Brown RW, Della Speranza V, Alvarez JO, Eisen RN, Frishberg DP, Rosai J, Santiago J, Tunnicliffe J, Colasacco C, Lacchetti C, Thomas NE. Uniform labeling of blocks and slides in surgical pathology: guideline from the College of American Pathologists Pathology and Laboratory Quality Center and the National Society for Histotechnology. Arch Pathol Lab Med. 2015 Dec;139(12):1515-24. [22 references] PubMed

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2015 Dec

Guideline Developer(s)

College of American Pathologists - Medical Specialty Society

National Society for Histotechnology - Professional Association

Source(s) of Funding

Both the College of American Pathologists (CAP) and National Society for Histotechnology (NSH) provided funding for the administration of the project; no industry funds were used in the development of the guideline. All panel members volunteered their time and were not compensated for their involvement.

Guideline Committee

College of American Pathologists (CAP) Pathology and Laboratory Quality Center Expert and Advisory Panel

Composition of Group That Authored the Guideline

Panel Members: Richard W. Brown, MD, Department of Pathology, Memorial Hermann Southwest Hospital, Houston, Texas; Vincent Della

Speranza, MS, HTL(ASCP), Department of Pathology and Laboratory Medicine, Medical University of South Carolina, Charleston; Janice O. Alvarez, HT(ASCP), Department of Pathology, Johns Hopkins Hospital, Baltimore, Maryland; Richard N. Eisen, MD, Department of Pathology, Greenwich Hospital, Greenwich, Connecticut; David P. Frishberg, MD, Department of Pathology and Laboratory Medicine, Cedars-Sinai Medical Center, Los Angeles, California; Juan Rosai, MD, Department of Pathology, University of Utah Medical School, Salt Lake City; Jerry Santiago, MSEd, HTL(ASCP) QIHC, Histologic Technology Program, Florida State College at Jacksonville, Orange Park; Janet Tunnicliffe, MLT, ART, Department of Laboratory Medicine and Pathology, Royal Columbian Hospital, New Westminster, British Columbia, Canada; Carol Colasacco, MLIS, SCT(ASCP), Governance, College of American Pathologists, Northfield, Illinois; Christina Lacchetti, MHSc, Quality and Guidelines Department, American Society of Clinical Oncology, Alexandria, Virginia; Nicole E. Thomas, MPH, CT(ASCP)^{CM}, Surveys, College of American Pathologists, Northfield, Illinois

Financial Disclosures/Conflicts of Interest

Conflict of Interest Policy

Prior to acceptance on the expert panel, potential members completed the College of American Pathologists (CAP) conflict of interest disclosure process, whose policy and form (in effect April 2010) require disclosure of material financial interest in or potential for benefit of significant value from the guideline's development or its recommendations 12 months prior through the time of publication. Potential members completed the conflict of interest disclosure form, listing any relationship that could be interpreted as constituting an actual, potential, or apparent conflict. Everyone was required to disclose conflicts prior to beginning and continuously throughout the project's timeline. Disclosed conflicts of the expert panel members are listed in the appendix of the original guideline document. Please see the supplemental digital content (see the "Availability of Companion Documents" field) for full details on the conflict of interest policy.

Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

Guideline Availability

Available from the Archives of Pathology & Laboratory Medicine Journal Web site .

Availability of Companion Documents

The following are available:

- Brown RW, Della Speranza V, Colasacco C, Lacchetti C, Thomas NE. Uniform labeling of blocks and slides in surgical pathology: guideline from the College of American Pathologists Pathology and Laboratory Quality Center and the National Society for Histotechnology. Supplemental digital content. 2015. 15 p. Available from the College of American Pathologists (CAP) Web site .
- Uniform labeling of blocks and slides in surgical pathology. Summary of recommendations. 2015. 2 p. Available from the CAP Web site .
- Uniform labeling of blocks and slides in surgical pathology: evidence-based guideline from the CAP and NSH. Frequently asked questions. 2015 Apr 21. 3 p. Available from the CAP Web site .
- Uniform labeling of blocks and slides in surgical pathology: guideline from the College of American Pathologists Pathology and the National Society for Histotechnology. Slide presentation. 2015 Apr 21. 49 p. Available from the CAP Web site .
- Uniform labeling of blocks and slides in surgical pathology. Infographic. 2015. 1 p. Available from the CAP Web site .

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI Institute on February 5, 2016. The information was verified by the guideline developer on March 9, 2016.

Copyright Statement

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